PRINTED: 10/13/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED		
		151328	B. WIN			08/17/2	.011	
NAME OF B	AN OLUBER OR GURNI IER				ADDRESS, CITY, STATE, ZIP CODE	1		
NAME OF P	PROVIDER OR SUPPLIEF	· ·	2900 W 16TH ST					
BEDFOR	D REGIONAL MED	DICAL CENTER		BEDFO	PRD, IN47421			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE	
S0000	man in a	g tr	90	000				
	This visit was to	r a State licensure survey.	So	000				
	Facility Number	: 004683						
	Dates: 8-16-11 t	through 8-17-11						
	Surveyors:							
	Billie Jo Fritch, Public Health Nu							
	Jennifer Hembre Public Health Nu							
	Ken Zeigler Laboratory Surv	eyor						
	Deborah Franco, Public Health No							
	QA: claughlin 0	9/19/11						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		151328	B. WIN			08/17/2	011
			F1		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			2900 W	16TH ST		
	RD REGIONAL MED	ICAL CENTER		BEDFO	RD, IN47421		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)		DATE
S0318	410 IAC 15-1.4-1(C)(6)(F)					
	for managing the had governing board so following: (6) Require that the officer develops perfor the following: (F) Ensuring cardinal cardinal for managing the had been so for the following:	hall do the e chief executive plicies and programs opulmonary					
	and hospital policy including contract provide direct pation	urrent standards of practice / for all health care workers, and agency personnel, who ent care.	60210				
		ent review and interview,	S0	318	Plan of Correction: 1. Physician notified 8-23-2011 of noncompliance Responsible: Director of Quality & Risk - Kathy		12/04/2011
	~ ~	ard failed to ensure					
	cardiopulmonary	resuscitation (CPR)					
	competence for 1	of 1 physician			Lewis, RN, MS	a rask radily	
	anesthesiologist	as required by the			Physician		
	medical staff rule	es and regulations.			Involved Educa Coordinator – Tony	tion	
	Findings include	:			Holt Completion Date: Recertified in ACLS Septemb 2011 2. Review Medical Star		
	1. Review of the	e credential file on			Rules and Regulations		
	8-16-11 for MD#	\$2, who was appointed			regarding "All physicians and		
	2-28-11, lacked 6	evidence the physician			allied health professional wl practice in high risk areas	IU	
	· ·	on of current ACLS			· · · · · ·	om,	
	certification.				internists on-call for the hosp		
		e medical staff rules and			anesthesia, and intensive of	care)	
					are required to be ACLS		
	regulations on 8-16-11 indicated the following: All physicians and allied			competent. Responsible: Director of Quality & Risk - K	athy		
		als who practice in high				CEO	
risk areas (defined as emergency room, internists on call for the hospital,				Administrative Assistant – Ka			
			Ellis Completion Date: Rev				
		ntensive care) are			to be completed by November	er 4,	
	l arresuresia, and n	110110110 0410) 410	ı		2011 3. Review, revise/or		

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	
		151328	B. WING			08/17/2	011
NAME OF PROVIDER OR SUPPLIER BEDFORD REGIONAL MEDICAL CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			2900 W	DDRESS, CITY, STATE, ZIP CODE 16TH ST RD, IN47421		(VS)	
(X4) ID				I	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL I SC IDENTIFYING INFORMATION)	"	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION DATE
IAG	required to be A0 competency will two years and wire-appointment to 3. Interview with hours confirmed	h #S2 on 8-17-11 at 1430 MD#2 provides oes not have current		IAG	develop policy or consistent process to ensure physicial BLS, ACLS, and PALS certification remains currer Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS CEO Administrative Assistant – Katellis Education Coordinator – Tony Holt Completion Date: Review, revision or development of process be completed by November 2011 4. Inservice/or Re-eduphysicians, education staff, administrative staff on the process to ensure physication remains current. Responsible: Director of Quality & Risk - Katewis, RN, MS Education Coordinator – Tony Holt Completion Date: Education be completed by December 2011 5. Monitoring of compliance with Physician B ACLS, and PALS Certification will be sto the Director of Quality more Responsible: Director of Quality more Responsible: Director of Quality More Responsible: Director of Quality & Risk - Kathy Lewis, MS Education Coordinator – Tony Holt CEO Administrative Assistant – Katellis Completion Date: Date abstracted and sent to Quality	nt. uality aren olicy to 4, ucate and elicy sician athy n to 4, LS, on sent nthly. , RN,	DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		151328	B. WING			08/17/2	011
			B. W11V		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			l	/ 16TH ST		
BEDFOR	D REGIONAL MED	ICAL CENTER		l	PRD, IN47421		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG DEFICIENCY)		DATE		
					beginning with December 1,	2011	
00556	440 140 45 4 5 0/	L .\			data		
S0556	410 IAC 15-1.5-2(D)					
	(b) There shall be	an active					
	effective, and writt						
	· ·	rogram. Included in					
	, ,	be system designed					
	for the identificatio						
		rol, and prevention					
	of infections and c diseases in patien						
	workers.	is and nealth care					
		ent review and interview,	80	556	Plan of Correction: 1.Reviev	v	06/01/2012
		to have an effective		330	facility policy concerning the		00/01/2012
	•				reliable proof of immunity		
		program to prevent the			varicella, rubeola, and rubell		
	•	inicable diseases in			Responsible: Director of		
	patients and heal	th care workers.			Quality & Risk - Kathy Lewis MS Director of		
	Findings include	:			Occupational Health – Brian Brazzell Completion Date: Review to be completed by	Occupational Health – Brian Brazzell Completion Date:	
	1. Review of per	rsonnel files on 8-16-11			November 4, 20112. Revise/	or	
	•	that 22 of 23 staff			develop policy concerning th		
		P#17, P#18, P#19, P#21 -			reliable proof of immunity		
	,	nented reliable proof of			varicella, rubeola, and rubell and develop a plan to bri		
	immunity to Vari	•			and develop a plan to bri existing	rig	
	_	rsonnel files on 8-16-11			employees into compliance.	Re	
	•				sponsible: Director of Quality		
		that 11 of 23 staff			Risk - Kathy Lewis, RN,		
		P#7, P#9 thru P#12,			MS Director of		
		0, P#21, and P#23) had			Occupational Health – Brian		
	documented relia	able proof of immunity to			Brazzell Completion Date: Revision or development of page 2.	ooliev	
	Rubeola.				and	Julicy	
	3. Review of per	rsonnel files on 8-16-11			the develo	opme	
	lacked evidence	that 5 of 23 staff			nt of a compliance plan to	.	
	members (P#1 P	P#10, P#14, P#21, and			be comple		
		nented reliable proof of			by December 4, 20113. Inse		
	1 π23 j nau uocun	nemed remadic proof of			staff on the policy concerning	g the	

li i		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		151328	B. WIN	G		08/17/2011
NAME OF I	PROVIDER OR SUPPLIER		·	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				1	16TH ST	
BEDFOR	RD REGIONAL MED	ICAL CENTER		BEDFO	RD, IN47421	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
	immunity to Rub				reliable proof of immunity to varicella, rubeola, and rubella	
	4. Interviews with #S1 and #S2 on				the plan to bring existing	a anu
	8-16-11 at 1620 l	nours confirmed the			employees into compliance	
	findings for the a	bove personnel and			Responsible: Director of	
	confirmed that th	ese staff members do not			Quality & Risk - Kathy Lewis	RN,
	have documented	l, reliable proof of			MS Director of	
	immunity to Rub	ella, Rubeola or			Occupational Health – Brian Brazzell Educa	tion
	Varicella.				Coordinator – Tony Holt	
	5. Interview with	n #S10 on 8-17-11 at			Completion Date: Education	to
	1500 hours confi	rmed the facility's			be completed by January 3,	
	infection control	program does not ensure			20124. Identify existing staff	that
		cumented, reliable proof			are not compliant with reliable proof of immunity	.
		prevented from working			varicella, rubeola, and rubella	
	' '	nity outbreak of Rubella,			Responsible: Director of Qua	
	_	ella in order to prevent			& Risk - Kathy Lewis, RN,	
		nmunicable diseases to			MS Director of	
	· •	health care workers.			Occupational Health – Brian Brazzell Emplo	Vee
	1 ^	at 2:45 PM, review of			Health Nurse Completion Da	
					Identification to be completed	l l
	personnel files ar				February 2,	
	employee E #2 ir				2012 5. Phase I plan	.
		S#31, S#32, S#33, S#34,			implementation to bring exist employees into compliance	
	l ' '	7) lacking reliable			reliable proof of immunity to	
		f history of or immunity			varicella, rubeola, and rub	ella.
	to Rubella.				Obtain lab draws on the first	50%
		S#31-S#37) lacking			of the identified facility	
		tation of history of or			employees Responsib Director of Quality & Risk - K	
	immunity to Rub	eola.			Lewis, RN, MS	auty
	c. 8 employees (S#31, S#32, S#33, S#35,			Director of Occupational Hea	lth –
	S#36, S#37, S#38	8, S#40) lacking reliable			Brian Brazzell	
	documentation of	f history of or immunity			Employee Health Nurse	_
	to Varicella. d. 2 employees (S#2, S#5) lacking			Completion Date: Phase I la draws to be completed	D	
				by March		
	1	f immunity to Hepatitis B			3,20126. Phase II plan	
		vaccine offered by			implementation to bring exist	ing

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		151328	A. BUILDING B. WING		08/17/2011
NAME OF PROVIDER OR SUPPLIER BEDFORD REGIONAL MEDICAL CENTER		STREE 2900	ET ADDRESS, CITY, STATE, ZIP CODE W 16TH ST FORD, IN47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	facility.			employees into compliance reliable proof of immunity to varicella, rubeola, and rub Obtain lab draws on the sect 50% of the identified facilitiemployees Responsible: Director of Quality & Risk - K Lewis, RN, MS Director of Occupational Health – Brian Brazzell Empl Health Nurse Completion Deprivate Phase II lab draws to be completed by April 2, 20117. Phase III plar implementation to bring existemployees into compliance reliable proof of immunity to varicella, rubeola, and rub Administer vaccinations to the first 50% of the identified facemployees. Responsible Director of Quality & Risk - K Lewis, RN, MS Director of Occupational Health Nurse Completion Date: Per III vaccine administration to completed May 2, 20128. Phase IV plar implementation to bring existemployees into compliance reliable proof of immunity to varicella, rubeola, and rub Administer vaccinations to the second 50% of the identified facility employees. Responsible: Director of Quality employees.	ella. bond y Cathy f oyee Date: n ting e for ella. ne acility : Cathy hase be by n ting e for ella. ne ality n ting e for ella. ne ality

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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Facility ID: 004683

If continuation sheet

Page 6 of 15

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO		(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI 08/17/20	
		151328	B. WIN			00/1//20	711
NAME OF I	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE		
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PREFIX	*	CY MUST BE PERCEDED BY FULL I SC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	Brazzell Employ Health Nurse Completion D Phase IV vaccine administrate to be completed by June 1, 20129. Monitoring compliance the facility policy concerning reliable proof of immunity to varicella, rubeola, and rub for new employees will be see the Director of Quality mo X 3 then quarterly X 3. Responsible: Director of Qual Compliance - Kathy Lewis, R MS Director of Occupational Health – Brian Brazzell Employ Health Nurse Completion Da Data to be abstracted and see	ate: tion e of the pella nt to nthly lity & N, yee ate: ent to innin 0. to into of of the	DATE

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII		00	COMPL	ETED		
		151328	B. WIN			08/17/2	011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 W 16TH ST BEDFORD, IN47421					
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S0596	and guide the inferprogram in the fact (3) The infection of responsibilities shanot be limited to, the (D) Reviewing and in procedures, polity which are pertinent control. These inclimited to, the following (iii) Cleaning, dising sterilization. Based upon document of the desired as procedured a	all establish an ommittee to monitor ction control ility as follows: ontrol committee all include, but ne following: I recommending changes cies, and programs t to infection clude, but are not wing:	S0	596	Plan of Correction: 1. Revior of the Departmental Policies Procedures concerning the challenge to the sterilization process for the 2 steam autoclaves in Central Supply Responsible: Central Supply Director, Sheila Doty, CMRP Completion Date: Review	and e	09/30/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151328		(X2) MUI A. BUILD B. WING		00	(X3) DATE S COMPL 08/17/20	ETED	
	PROVIDER OR SUPPLIER			2900 W	DDRESS, CITY, STATE, ZIP CODE 16TH ST RD, IN47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
	Manual states th process challeng routine sterilizer least weekly (but hat the sterilizer implant". 2. During tour of on 8/17/2011 at presence of E #1 log was reviewed indicator process performed only of implantables. 3. During interviewed indicator process performed only of implantables.	ral Service Technical at "Biological indicator e should be used for efficacy monitoring at t preferrably every day) is used, and with every f the central service area 12 noon, and in the and E #14, the biological d and revealed biological s challenges were			completed September 15, 20 2. Revision of the Departmer Policies and Procedures concerning the challenge to sterilization process for the steam autoclaves in Central Supply Responsible: Central Supply Director, She Doty, CMRP Completion Date: Revision completed September 19, 2011 3. Inservice/or Re-educate Central Supply son the revision of the Departmental Policies and Procedures concerning the challenge to the sterilization process for the 2 steam autoclaves in Central Supply Responsible: Central Supply Responsible: Central Supply Responsible: Central Supply Mitchum Completion Date: Education completed Septem 19, 2011 4. Monitoring log implemented and biological indicator for validating the sterilization process has beg Responsible: Central Supplication process has beg Responsible: Central Supplication Date: Implemented September 19, 2011 5. Monitoring of compliance with validating the sterilization process will be sent to the Director of Quality Monthly and Quarterly X3. Responsible: Director of Quality Monthly and Quarterly X3.	ental the the 2 ila ate: per staff y 3 M nber un. pply nted h X 3 ality S ila ate:	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		151328	B. WIN			08/17/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				/ 16TH ST		
BEDFOR	RD REGIONAL MED	OICAL CENTER		I	PRD, IN47421		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	, <u> </u>	DATE
					quality beginning with Octo	ber 1,	
					2011 data		
S1118	410 IAC 15-1.5-8	(b)(2)					
	(b) The condition (of the physical					
	plant and the over						
		be developed and					
		h a manner that the					
	safety and well-be						
	assured as follows	5:					
	(0) 11	1.111					
	(2) No condition s						
	maintained which may result in a hazard to patients, public, or employees.						
	1	ation, document review,	S1	118	Plan of Correction: 1. The		01/03/2012
		e facility created		110	seven (7) fire extinguishers v	vere	01/03/2012
	l '	n could result in hazards		removed from the Maintenance		ınce	
					shop floor and stored		
	_	ors, and staff in 1 of 1			appropriately Responsible		
	1	artment and 1 of 1			Director of Physical Plant – F		
	ambulance garag	ge.			Crulo Completion Date: Au 17, 2011 The one (1) unsec		
					oxygen tank was removed fr		
	Findings include	:			Ambulance garage desktop		
					secured in the O2 cabinet		
	1. While touring	the facility on 8-17-11 at			Responsible: Director of EN		
	1115 hours in the	e presence of #S3, seven			Bob Atkins Completion Dat	e:	
		hers were observed			August 17, 2011 2. Review		
	` ′	floor in the maintenance			Environment of Care policy concerning the storage of	fire	
	department.	The state of the s			extinguishers and oxygen tai		
	1 ^	the facility on 9 17 11 et			Responsible: Director of	0	
		g the facility on 8-17-11 at			Quality & Risk - Kathy Lewis	, RN,	
		e presence of #S3, an			MS Completion Date: Revi		
	• •	observed unsecured on a			to be completed by Novembe	er 4,	
	desk in the ambu	0 0			2011 3. Revision of the		
	3. Interview with #S3 on 8-17-11 at 1115				Environment of Care policy	6	
	hours and 1145 hours respectively			concerning the safe storag			
		sence of 7 unsecured fire			fire extinguishers and oxyget tanks Responsible: Direct		
					of Quality & Risk - Kathy Lev		

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151328	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 08/17/2	LETED
	PROVIDER OR SUPPLIER		2900 W	ADDRESS, CITY, STATE, ZIP CODE / 16TH ST DRD, IN47421	I	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	in the ambulance	the maintenance I unsecured oxygen tank garage which can result tients, visitors, and staff.		storage of fire extinguish oxygen tanks Responsible: Director of & Risk - Kathy Lewis, RN MS Educati Coordinator – Tony Holt Completion Date: Educate be completed by January 2012 5. Monitoring of cowith safe fire extinguishe oxygen tank storage will to the Director of Qual monthly X 3 then Quarter Responsible: Director Quality & Risk - Kathy Lo	staff on he safe ers and f Quality l, on ation to a 3, mpliance or and be sent ty ly X 3 of ewis, RN, of Plant or of pletion ted and	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151328		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 08/17/2	ETED	
	PROVIDER OR SUPPLIER		•	2900 W	DDRESS, CITY, STATE, ZIP CODE 16TH ST RD, IN47421		
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S1172	fixtures, walls, floor furnishings throug clean and orderly current standards follows: (1) Environmental provided in such a against transmissi patients, health capublic, and visitors current principles (A) Asepsis (B) Cross-infection (C) Safe practice. Based on observation hospital failed to anesthesiology pure current standards Findings include 1. On 8/17/2011 the facility and in and E #12, the follow a. Operating Roupyxis machine's dusty. The work contained areas of substance.	buildings, including ors, ceiling, and hout, shall be kept in accordance with of practice as services shall be way as to guard on of disease to are workers, the soly using the of the following: n; and ation and interview, the ensure 2 of 2 yxis machines were kept or in accordance with sof practice.	S1	172	Plan of Correction: 1. The (2) pyxis machines in OR we cleaned. Responsible: Director of Anesthesia Completion Date: August 1' 2011 2. Review Anesthesia poncerning the infection corresponsibilities for Anesthesia Responsible: Director of Quality & Risk - Kathy Lewis, MS Director of Anesthesia Completion Date: Review to completed by November 4, 2011 3. Revision of the Anesthesia policy concerning infection control responsibilities for Anesthesia Responsible: Director of Quality & Risk - Kathy Lewis, MS Director of Anesthesia Completion Date: Revision be completed by December 4, 2011 4. Inservice/or Re-edu	re 7, poolicy ntrol a. RN, p be g the a RN, to 4,	01/03/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **OKLQ11** Facility ID: 004683 If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		no Com			(X3) DATE S COMPL		
151328		A. BUILDING B. WING		08/17/2011			
NAME OF PROVIDER OR SUPPLIER BEDFORD REGIONAL MEDICAL CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 2900 W 16TH ST BEDFORD, IN47421 ID PROVIDERS PLAN OF CORRECTION (X5)				
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETIO DATE	COMPLETION DATE
	pyxis machine's a dusty. The work contained areas of substance. d. The cart in Oldof routine cleaning. 2. E #12 verified beginning at 2:30 following: a. Each operating security controlled by the anesthesian b. The pyxis may operating rooms splattered dried with the substance of the substance o	om #4's anesthesiology surfaces and sides were ing surface of the cart of a splattered dried white R #4 showed no evidence ng. I, during interview O PM on 8/17/2011, the g room (2) contains a ed pyxis machine for use a department. Inchines in these two (2) were dusty, had a white substance on the and lacked evidence of			staff on the Anesthesia policy concerning the infection contresponsibilities for Anesthesia Responsible Director of Quality & Risk - K Lewis, RN, MS Director of Anesthesia Completion Dat Education to be completed by January 3, 2012 5. Monitorin compliance with infection control responsibilities of Anesthesia will be sent to the Director of Quality monthly then Quarterly X 3 Responsible: Director of Quality MS Director of Anesthesia Completion Dat Data to be abstracted and se Quality beginning with January 1, 20 data	rol : athy e: y ng of f e y X 3 ality e: nt to	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED			
		151328				08/17/2011		
			B. WINC		DDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER			2900 W	16TH ST			
BEDFORD REGIONAL MEDICAL CENTER		ICAL CENTER	BEDFORD, IN47421					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION			
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		E	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG DEFICIENCY)			DATE	
S1186	410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v) (f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following: (A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (iii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.							
	the facility fire coensure night shift appropriate training appropriate training Findings include 1. Review of fact 8-17-11 lacked excontrol plan ensure staff received the shift staff; facility	ent review and interview, control plan failed to the health care workers had ing in the event of a fire. Eility documents on widence that the fire ared that the night shift exame fire training as day by documents indicated of conducted at the	S11	186	Plan of Correction: 1. Silen Fire Drill held at 11:05 pm. Responsible: Director of Quantum Review Review to Completed by November 4, 23. Revision of the Environment Care policy concerning the facility fire plan and drills Responsible: Director of Quantum Responsi	ality Ser ment he ality Sobe 011 ent of	01/03/2012	
	facility on the night shift for 4 of 4				& Risk - Kathy Lewis, RN, MS Completion Date: Revision	s		

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	A. BUILDING			COMPLETED 08/17/2011		
151328			B. WIN			00/17/20	/ 1 1	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
DEDECIDE DECIONAL MEDICAL CENTED				2900 W 16TH ST				
BEDFORD REGIONAL MEDICAL CENTER			BEDFORD, IN47421					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL PEGLIL ATORY OF LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)		
PREFIX TAG			'	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLETIC	COMPLETION	
IAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			IAU	be completed by December 4,		DATE	
	quarters (3rd and 4th quarters in 2010 and 1st and 2nd quarters in 2011) to ensure the competency of night shift staff. 2. Interviews with #S3 and #S12 on 8-17-11 at 1045 hours confirmed the				2011 4. Inservice/or Re-edu	· .		
					staff on the Environment of			
					Care policy concerning the facility fire plan and drills Responsible: Director of Quality			
					& Risk - Kathy Lewis, RN,	lailty		
	facility has not ensured the fire safety competency of the night shift staff by conducting fire drills for the night shift, including any drills after 5:00 p.m., during the 3rd and 4th quarters in 2010 or the 1st				MS Education			
					Coordinator – Tony Holt			
					Completion Date: Education	n to		
					be completed by January 3, 2012 5. Monitoring of compl	iance		
					with fire drill timing will be			
	and 2nd quarters in 2011.				to the Director of Quality			
					Quarterly Responsib l			
					Director of Quality & Risk - K			
					Lewis, RN, MS Completion Date: Data to be abstracted			
					sent to	and		
						ginnin		
					g with Qtr 4 2011 data			